



EMU Referral Form

Fax to: 720.287.5344 - Please Attach Medical Records With This Form
(ALL ITEMS MARKED WITH * MUST BE COMPLETED)

Patient Name*: _____

Home Phone*: _____ Alternate Phone: _____

Previous Monitoring*: _____ Insurance Carrier*: _____

ID/Policy Number*: _____ Group/Plan: _____

Provider Requested:

ENGLEWOOD: Kirsten Bracht, MD Richard Clemmons, MD First Available /
 Kimberly Horiuchi, MD Charles Livsey, MD, PhD No Preference

WHEAT RIDGE: Kirsten Nielsen, MD

Referred For: (check ONE only)

Pre-surgical Monitoring Characterization Only Assessment of Current Medication Efficacy

ICD-10: _____ **CPT: 95951** continuous EEG with Video, each 24 hrs.

Seizure Type*: (check all that apply)

Simple Partial Complex Partial Generalized Tonic Clonic Absence Unknown

Seizure Frequency*: _____

Medication*:

Do you want meds withdrawn during EMU? Yes No Epilepsy Physician to decide
Do you want VNS turned off during EMU? Yes No N/A

Special Needs*: (check all that apply)

Nocturnal O2 Wheelchair Interpreter Other: _____

MRI Information*: Date of last MRI: _____ Facility: _____

Is a repeat MRI needed? Yes No

Patient Concerns*: _____

Prior Auth Status*: _____

Referring Physician*:

Physician Signature: _____ Date: _____

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